STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 11, 12, 13, 14, 15, and 20, 2011 Facility number: 000253 Provider number: 155362 AIM number: 100266660 Survey team: Kelly Sizemore, RN-TC Sheila Sizemore, RN Marcia Mital, RN Regina Sanders, RN (July 11, 12, 13, 14, and 15, 2011) Census bed type: SNF/NF: 151 Total: 151 Census payor type: Medicare: 15 Medicaid: 118 Other: 18 Total: 151 Sample: 24 Supplemental sample: 9 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal rgulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	16.2. Quality review completed on July 25, 2011 by Bev Faulkner, RN			
F0157 SS=E	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation, record review, and interview, the facility failed to ensure residents' physicians were notified in a timely manner related to blood sugars, pressure sores, significant weight loss, skin condition, and a urine specimen not obtained, for 5 of 24 residents reviewed for physician notification in a total sample of 24. (Resident's #27, #48, #59, #83, #105) Findings include: 1. Resident #27's record was reviewed on 7/12/11 at 12:20 p.m. Resident #27's diagnoses included, but were not limited to, diabetes, hypertension, and multiple sclerosis. A dining services note, dated 4/25/11 at 1:20 p.m., indicated "...WT: (weight) 193.2# (pounds) upon readmission which shows weight changes of...-12.18% past 180 days...Plan: Recommend continue with current nutrition interventions. Will continue to monitor weight changes weekly. Will f/u (follow up) as needed." There was a lack of documentation the physician was notified of the significant weight loss. There was a lack of documentation in the nurses's notes the physician was notified of the significant weight loss.	F0157	F157 Resident #27 MD was notified on 7/14/11. New Registered Dietician has since been employed and is aware of policy for notification. Resident #59 MD was made aware as noted in the citation. Resident #48 MD was notified on 5/24/11 after several unsuccessful attempts to reach attending. Resident #83 Nurse Practitioner has since been notified and continued treatment order. Resident #105 bug bites have since been resolved and MD aware. Any resident with a significant weight loss greater than 10 percent in 180 days have the risk of this alleged deficient practice, residents' current records have been reviewed to ensure notification has taken place as per policy with any of those that meet these criteria. Any resident with UA's ordered have the risk of this alleged deficient practice. Lab log for the month of July was reviewed to ensure all UA's ordered have appropriate notification as per policy. Any resident with orders for blood sugar tests run the risk of this alleged deficient practice. Residents with these orders in the month of July were audited for notification. Skin assessment on Resident #83 was completed on 7/14/11. There were no other residents identified with bug bites. Nurses will be re-educated on the MD notification procedure, which	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An undated facility policy titled, "Weight Monitoring," received as current from the Administrator on 7/14/11 at 3:45 p.m., indicated "Significance of weight loss: ...six months significant loss 10 percent, severe loss greater than 10 percent...Notification: When weight change is significant or severe, the licensed nurse will notify the resident's physician..." During an interview with the Registered Dietician, on 7/14/11 at 9:30 a.m., she indicated the resident's physician should have been notified around the time of 4/25/11, of the weight loss greater than 10 percent in 180 days. 2. Resident #59's record was reviewed on 7/12/11 at 9:30 a.m. Resident #59's diagnoses included, but were not limited to, diabetes, hypertension, and dementia. The nurse's notes indicated the following: 6/20/11 at 2:44 p.m., "Assessment:...stated it hurts when he wants to void...Response: MD notified orders to obtain urine for culture and sensitivity..." 6/20/11 at 10:37 p.m., "Resident complain of Pain urination UA (urinalysis), C&S		includes when to call the medical director when attending does not return calls promptly. During our weekly meetings that we discuss weight concerns, Registered Dietician or designee will review records from that week of those that meet the criteria to ensure that notification has taken place. DNS or licensed designee will audit the lab book five times a week to ensure that all UA orders and blood sugars are being followed up on and notified per policy. DNS or licensed designee will also review 5 charts weekly for continued compliance of notification for bug bites. Corrective action and re-education will take place from to ensure the alleged deficient practice does not reoccur. Any deficient practice will be reviewed and quantified in our QA&A committee for at least 3 months with 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(culture and sensitivity), Straight catch ordered." 6/21/11 at 6:16 a.m., "...Unable to obtain u/a/c+s (sic) this shift..." 6/21/11 at 11:19 a.m., "...unable to obtain u/a et (and) c/s will endorse to next shift..." 6/21/11 at 11:11 p.m., "try to do straight cath for UA and C&S, resident refused, try to used (sic) urinal bottle, per resident he can't void..." 6/22/11 at 00:59 (sic) a.m., "Resident was straight cathed x 1 at beginning of shift, unable to get urine at that time..." 6/22/11 at 3:52 a.m., "Attempted again to obtain u/a via straight cath, unable to obtain urine..." 6/22/11 at 3:09 p.m., "Resident has an order to get an UA via straight cath...Staff has been unsuccessful for 3 days. Writer called MD..." An Alteration in elimination of bowel and bladder care plan, dated 6/2/11, indicated "Interventions: Monitor and report changes in ability to toilet..." During an interview with LPN #8, on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7/12/11 at 11:45 a.m., she indicated "When I identified no urine had been obtained, I told them to call the doctor." 3. Resident #48's record was reviewed on 7/11/11 at 12:40 p.m. Resident #48's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, and stoke. A physician's order, dated 3/24/11, indicated accu-check (blood sugar test) twice a day. Notify MD if blood sugar was greater than 300. The resident's MAR (Medication Administration Record) dated 5/11, indicated the resident's blood sugars were greater than 300 at 4 p.m., on 5/11/11 330, 5/12/11 383, 5/21/11 312, and 5/22/11 350. The nurses' notes lacked documentation for the above dates to indicate the physician had been notified of the resident's blood sugars greater than 300. During an interview on 7/12/11 at 10:15 a.m., LPN #7 indicated there physician should have been notified of the resident's blood sugars. 4. Resident #83's record was reviewed on 7/14/11 at 2:00 p.m. Resident #83's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diagnoses included, but were not limited to, stroke, arthritis, and dysphagia (difficulty swallowing). Resident #83 was observed on 7/14/11 at 1:50 p.m., during a skin check with CNA #9 , CNA #10, and LPN #11 present. The resident had an stage II pressure ulcer on her right lower buttock which measured 2.5 centimeters by 0.4 centimeters. The physician progress notes, dated 7/12/11, written by the Nurse Practitioner, indicated the pressure ulcer on the resident's right buttock was closed. During an interview on 7/15/11 at 9:40 a.m., the DoN (Director of Nurses) indicated the pressure ulcer to the resident's right buttock had healed per the Nurse Practitioner on 7/12/11 and now had re-opened. She indicated the physician had not been notified of the pressure ulcer re-opening. 5. Resident #105's record was reviewed on 7/15/11 at 9:20 a.m. Resident #105's diagnoses included but, were not limited to, infantile cerebral palsy, peripheral neuropathy, and depression. The next nurses' note after 6/09/11 at 8:57 p.m., indicated an undated nurses' note for change of condition, indicated "Situation: Noted red spots on resident's face that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resembles bug or mosquito bite...paged md (medical doctor) and waited for call back, will endorse to incoming staff to notify md for tx (treatment) order in am." The nurses' notes lacked documentation of the resident's physician being notified of the red spots from 6/9/11 to the present of 7/15/11. During an interview on 7/15/11 at 9:45 a.m., the DoN indicated Resident #105's physician had not been notified of the red spots. An undated facility policy, titled "Notification of Change in Resident Health Status" received from the Unit Manager, LPN #8, on 7/12/11 at 11:30 a.m., who indicated the policy was current, indicated "Notification: within 24 hours from the time of an assessment has been made indicating there may be a potential for physician intervention...." 3.1-5(a)(2) 3.1-5(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0203 SS=D	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. Based on record review and interview, the facility failed to provide residents with a notice of transfer or discharge, which informed the resident of the reason for the transfer or discharge, the information about the right to appeal the action, and the name and number of the State long term care ombudsman, for 3 of 3 residents' closed records reviewed in a sample of 24. (Residents #152, #153, and #154) Findings include: 1. Resident #154's closed record was reviewed on 07/14/11 at 8:20 a.m. The resident's diagnoses included, but were not limited to, neoplasm of the spinal cord and kidney, congestive heart failure, and chronic pain. The record indicated the resident had been discharged from the facility on 06/02/11. A Physician's Order, dated 06/02/11,	F0203	F203 Resident #152, 153 and 154 no longer reside in the building. Any resident with orders to discharge or transfer from the building have the potential to be affected by this alleged deficient practice. Social Services and Nursing department have since been re-educated on the importance of providing this paperwork upon discharge as per policy. During Morning meeting five times a week, discharges will be reviewed in discussion by Executive Director or designee with social services or designee to ensure that all notices were given and copied for proof as per policy to ensure this practice does not reoccur. Any deficient practice will be reviewed and quantified in our QA&A committee for at least 3 months with 100% compliance	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident had an order to be transferred to the hospital Emergency Room for evaluation and treatment. There was a lack of documentation to indicate the resident received a notice of transfer or discharge. During an interview on 07/14/11 at 1:50 p.m., the Director of Nursing indicated the facility does not do the notice of transfers. 2. Resident #152's closed record was reviewed on 7/14/11 at 8:30 a.m. Resident #152's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and Alzheimer's disease. A physician's order, dated 6/17/11, indicated to discharge the resident home on 6/18/11. The resident's record lacked documentation to indicate the resident or family had received notice of transfer or discharge. During an interview on 7/15/11 at 11:25 a.m., the Director of Nurses indicated they had not been completing the notice of transfer or discharge forms. 3. Resident #153's closed record was reviewed on 7/14/11 at 8:20 a.m. Resident #153's diagnoses included, but were not limited to, hypertension,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	congestive heart failure, and depression. A physician's telephone, dated 6/28/11, indicated the resident was to be discharged home. There was a lack of documentation to indicate the resident received a notice of transfer or discharge. 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F0253 SS=B	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable interior related to dried, spilled liquid on the wall, loose cove base, chipped and	F0253	F253 ACU Boutique was cleaned and loose cove base re-secured, piano was sanded and stained, corner tiles replaced, toilet chair replaced, vents painted, air conditioner cleaned, floor swept in main dining room before state exited on 7/20/11.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rough boards on a piano, missing tile and corner trim in a shower room, scraped off metal covering on a toilet chair, stained ceiling vents, and dirty air conditioner on the Alzheimer's Care Unit, which had the potential to affect 31 residents who reside on the unit and an accumulation of dirt on the floor under the counter in the main dining room. (Alzheimer's Care Unit (ACU) and Main Dining Room) Findings include: 1. During the environmental tour on 07/14/11 at 10:25 a.m. through 11:55 a.m., with the Administrator, Housekeeping Supervisor, and Maintenance Director, the following was observed: A) ACU: 1. There was a red, dried substance on the trim of the wall and loose cove base in the Boutique. During an interview at the time of the observation, the Administrator indicated the dried, red substance could be kool-aide or punch. 2. The piano in the Sunroom had chips in the wood and the key cover had unsanded wood and was rough to touch. 3. There was a missing corner tile and		All areas of the building present a potential to be affected in the same manner. A complete tour of the building was completed on 7/15/11 to ensure that any areas that presented the same concern were addressed immediately. Housekeeping supervisor and Maintenance Director were educated on the need to make sure rounds are done with attention to detail repeatedly through the week to maintain compliance. Rounds will be made with Housekeeping supervisor and Exec Director five times a week to ensure that facility is sanitary, orderly and comfortable interior maintained. Any deficient practice identified will be action planed to ensure that the process maintains the facility in compliance. Action Plans will be reviewed in QA & A committee for monitoring 3 months with 100% compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	corner trim, which left a brown substance on the tiles in the shower room. The toilet chair over the toilet had a missing metal covering. During an interview at the time of the observation, the Administrator indicated the tiles needed replaced. 4. There were five vents in the B-hallway which had brown stains on them. The Administrator indicated at the time of the observation, the stains do not come off and the vents would need to be painted. 5. The air conditioner in the, "Saloon" had an accumulation of dirt and a thick brown substance in the vents. The Administrator acknowledged the thick brown substance at the time of the observation. B) There was an accumulation of dirt on the floor under the counter at the entrance of the Main Dining Room. At the time of the observation, the Administrator acknowledged the dirt. 3.1-19(e)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0280 SS=E	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to develop and update resident's plans of care related to cognitive loss, ADL (activities of daily living), urinary incontinence, falls, and pressure ulcers for 4 of 24 resident's	F0280	F280 For residents #13, 48, 83, and 140 have all had care plans printed and placed in charts accordingly. Residents with triggers on MDS for ADL, Urinary Incontinence,	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for care plans in a total sample of 24. (Residents #13, #48, #83, and #140) Findings include: 1. Resident #140's record was reviewed on 7/13/11 at 10 a.m. Resident #140's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and congestive heart failure. An admission MDS (Minimum Data Set) assessment, dated 5/28/11, indicated the resident had triggered for ADL function and falls and the facility was proceeding to care plans. The resident's care plans, dated 3/30/11 and updated 5/12/11, lacked documentation of care plans for falls and ADL's. During an interview on 7/13/11 at 12:30 p.m., LPN #7 indicated there were no care plans for ADL's or falls for the resident. 2. Resident #48's record was reviewed on 7/11/11 at 12:40 p.m. Resident #48's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, and stroke. An annual MDS assessment, dated 1/6/11,		falls, cognitive loss, and pressure ulcers present a potential to be affected by the alleged deficient practice. Residents who had an MDS in the month of July were reviewed to ensure care plans are in place for the areas mentioned above. MDS, Unit Managers and Social Services were all re-educated on the importance of ensure updated care plans are printed and placed in chart timely per policy. Weekly care plan meetings will include an audit tool to monitor and ensure these triggered areas are care planned according to policy. MDS coordinator or licensed designee to complete these tools and report any deficiencies timely to ensure alleged deficient practice does not reoccur. These weekly tools will be reviewed in QA&A committee to ensure compliance is 100% consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident had triggered for urinary incontinence and ADL function and the facility was proceeding to care plans. The resident's care plans, dated 2/26/10 and updated 7/5/11, lacked documentation of care plans for ADL function and urinary incontinence. During an interview on 7/12/11 at 10:50 a.m., MDS coordinator #12 indicated she was not sure why the resident's care plans for ADL and urinary incontinence were not in the resident's record. 3. Resident #83's record was reviewed on 7/14/11 at 2 p.m. Resident #83's diagnoses included, but were not limited to, stroke and arthritis. An admission MDS assessment, dated 6/29/11, indicated the resident had triggered for cognitive loss and the facility was proceeding to care plan. The resident's care plans, dated 6/22/11 and updated 7/6/11, lacked documentation of a care plan for the resident's cognitive loss. During an interview on 7/15/11 at 10:30 a.m., LPN #7 indicated there was not a care plan for cognitive loss.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Resident #13's record was reviewed on 7/12/11 at 11:42 a.m. Resident #13's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and debility. A wound evaluation flow sheet, dated 5/14/11, indicated Resident #13 had a pressure ulcer to the right ischial. The wound evaluation flow sheets indicated the pressure ulcer was being evaluated on a weekly basis. The wound evaluation flow sheet, indicated on 6/1/11 an intervention of "laid down after each meal" was added. An actual pressure ulcer care plan, dated 6/14/11, lacked documentation of the intervention for the resident to be laid down after each meal. During an interview the Unit Manager, LPN #8 indicated the intervention had not been placed on Resident #13's care plan. 3.1-35(c)(1) 3.1-35(d)(2)(9)(B)	F0280	F280 For residents #13, 48, 83, and 140 have all had care plans printed and placed in charts accordingly. Residents with triggers on MDS for ADL, Urinary Incontinence, falls, cognitive loss, and pressure ulcers present a potential to be affected by the alleged deficient practice. Residents who had an MDS in the month of July were reviewed to ensure care plans are in place for the areas mentioned above. MDS, Unit Managers and Social Services were all re-educated on the importance of ensure updated care plans are printed and placed in chart timely per policy. Weekly care plan meetings will include an audit tool to monitor and ensure these triggered areas are care planned according to policy. MDS coordinator or licensed designee to complete these tools and report any deficiencies timely to ensure alleged deficient practice does not reoccur. These weekly tools will be reviewed in QA&A committee to ensure compliance is 100% consecutively for 3 months.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure physician's orders and residents' plans of care were followed related to medications, laboratory tests, and a wanderguard for 5 of 24 residents reviewed for following physician's orders and plans of care in a total sample of 24 (Residents #36, #129, #135, #140, and #154) and for 1of 9 resident's in a supplemental sample of 9. (Resident #150) Findings include: 1. Resident #36's record was reviewed on 7/12/11 at 11:15 a.m. Resident #36's diagnoses included, but were not limited to, stroke, hypertension, and anemia. A physician's order, dated 5/11/11, indicated to discontinue vitamin D. The resident's MAR (Medication Administration Records), dated 6/11 and 7/11, indicated the resident received the vitamin D the month of June and July. During an interview on 7/12/11 at 3:35 p.m., LPN #7 indicated the vitamin D had been discontinued on 5/11/11. She	F0282	F282 Resident #39 MD notified of medication error. Resident #135 wanderguard is in place and orders since. Resident #140 prealbumin level was obtained during survey. Resident # 129 MD order was clarified on MAR, med error was completed. Resident # 150 MD was notified and order clarified. Med error form was completed. Resident # 154 has since discharged , NP was notified. Residents with discontinued medication orders are at risk for this alleged deficient practice. All residents in the month of July with DCd medication orders were reviewed to ensure that the alleged deficient practice did not affect other residents. During survey all residents with active orders for wanderguard were checked for placement, no other concerns were identified. All residents with orders in the month of July for prealbumin level checks were reviewed for compliance and physicians notified accordingly. Any residents with Exelon patch orders are at risk for this alleged deficient practice. All residents with this order in the month of July were checked that MAR matched Phys order for application. Residents that go to	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated it had been missed on the MAR in June and July. She indicated it was a medication error. 2. Resident #135's record was reviewed on 7/12/11 at 4 p.m. Resident #135's diagnoses included, but were not limited to, dementia, hypertension, stroke, and failure to thrive. A physician's order, dated 5/24/11 indicated "wonder(sic) guard to be worn at all times. Check placement every shift." Resident #135 was observed lying bed on 7/12/11 at 5:16 p.m. There was not a wanderguard on the resident's ankles. The resident removed the wanderguard from under his pillow. He indicated the wanderguard had come off. He indicated he was not sure when it had come off. During an interview on 7/12/11 at 5:20 p.m., LPN #1 indicated the wanderguard should be on the resident's ankle. 3. Resident #140's record was reviewed on 7/13/11 at 10 a.m. Resident #140's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and congestive heart failure. A physician's order, dated 6/24/11, indicated to obtain a pre-albumin level (a		an outside ophthalmologist are at risk for this alleged deficient practice. Residents who went to an outside appnt with eye doctor for the month of July had orders reviewed for accuracy.Any resident with order for Dilaudid are at risk for this alleged deficient practice. All residents with an active order for Dilaudid in the month of July were reviewed for receiving correct dosage. Licensed nursing staffs were reeducated on following MD orders, and Albumin vs Prealbumin orders. Unit Managers or licensed designee will review list of residents seen by nurse practitioner for new orders written and ensure they are followed through with at each NP visit. DNS or Licensed designee will verify placement of wanderguard weekly. DNS or Licensed designee will review 100% of prealbumin lab orders to ensure that correct labs are drawn. DNS or Licensed designee will review 5 residents receiving narcotics weekly for correct dosage given. The results of the reviews above for compliance will be presented monthly in QA&A for 3 months with 100%compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

test for protein levels) due to non-healing ulcer.

The resident's record lacked documentation of the pre-albumin level.

During an interview on 7/13/11 at 12:30 p.m., LPN #7 indicated the pre-albumin had not been done. She indicated it was being drawn now. She indicated the nurse had filled out the laboratory slip wrong and had ordered an albumin level instead of a pre-albumin level.

4. Resident #129's record was reviewed on 7/13/11 at 9:50 a.m. Resident #129's diagnoses included, but were not limited to, dementia, depression, and anxiety.

A physician's order, dated 4/13/10, indicated "Exelon (anti-Alzheimer's drug) 4.6 mg (milligrams)/24 HR (hour) patch 24 hour transdermal-two times a day everyday: apply one patch topical daily rotate sites."

The MAR (Medication Administration Record) for the months of May, June, and July of 2011, indicated the exelon 24 hour patch was being applied at 9:00 a.m. and removed at 5:00 p.m. everyday.

During an interview on 7/13/11 at 10:35 a.m., the day shift nurse, LPN #13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

indicated she put a new exelon patch on this morning. LPN #13 indicated there was no exelon patch on the resident when she applied the one this morning.

During an interview on 7/13/11 at 10:40 a.m., the DoN indicated there was a medication error for the exelon. The DoN indicated she would also clarify the physician's order as the exelon was a 24 hour patch.

5. Resident #150's record was reviewed on 07/12/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, open-angle glaucoma and hypertension.

A Physician's Order, dated 06/24/11, indicated an order for Restasis (anti-inflammatory agent) ophthalmic solution, one drop each eye at 8 a.m. and 8 p.m.

The Medication Administration Record (MAR), dated 07/11, indicated an order for Restasis ophthalmic, two drops in both eyes, twice daily. The MAR indicated by initials the resident received two drops into each eye twice a day on July 1, 2011 through July 11, 2011.

During an interview on 07/12/11 at 9 a.m., LPN #1 indicated she did not know if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurses were giving one or two drops of the Restasis. She indicated they were initialing they were giving two drops of the Restasis eye drops. 6. Resident #154's closed record was reviewed on 07/14/11 at 8:20 a.m. The resident's diagnoses included, but were not limited to, neoplasm of the spinal cord and kidney, and chronic pain. The Physician's Recapitulation Orders, dated 05/26/11 through 05/31/11, indicated an order, dated 05/27/11 for Dilaudid (narcotic pain medication) 2 mg (milligram), give 6 mg (three tablets) every three hours as needed for chronic pain. The MAR, dated 06/11, indicated Dilaudid 2 mg, one tablet was given on 06/02/11 at 6:30 a.m. for generalized pain. The Controlled Drug Record, dated 05/28/11, indicated one tablet of the Dilaudid 2 mg was signed out by the nurse. During an interview on 07/14/11 at 9:20 a.m., the Director of Nursing indicated the nurse did not give the correct dose of Dilaudid. A facility policy, dated 09/10, titled,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Medication Administration General Guidelines", received as current from the Director of Nursing, indicated, "...Medications are administered in accordance with written orders of the prescriber...Verify medication is correct three (3) times before administering the medication..." 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide incontinence care for 2 of 11 residents who were dependent on staff for incontinence care in a sample of 24. (Residents #13 and #83) Findings include: 1. Resident #13 was observed on 7/12/11 at 9:09 a.m., up in her Broda chair (type of wheelchair) in the rehab dining room. Resident #13 was observed in the same location in the rehab dining room on 7/13/11 at 11:35 a.m. Resident #13 was observed being taken to her room at 12:25 p.m. by CNA #15. The CNA indicated she had gotten the resident up at 7:30 a.m., and had not changed her since getting her up. The resident was placed into bed at 12:37 p.m., the resident's brief was wet and the dressing to the right buttock was soaked. CNA #15 indicated the resident was wet and the resident's dressing was wet with urine. CNA #15 indicated it had been five hours since she had gotten the resident up.	F0312	F312 Resident #13 was provided care during survey and her open areas have since healed. Resident#83 was also provided care during survey. C.N.A. responsible for their care was given 1:1 re-education concerning incontinent care. Any resident who is dependent for incontinence care during survey is at risk for this alleged deficient practice. Other dependent residents were checked and no further problems were identified. Education was provided to nursing staff regarding incontinent care. DNS or Licensed designee will check 5 dependent incontinent residents daily, five times a week for compliance. Education will be provided at the time any resident is found not in compliance. The results of the review will be presented monthly in QA&A until 100% compliance is achieved consecutively for 3 months.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview on 7/12/11 at 1:00 p.m., Unit Manager, LPN #8 indicated the resident should have been changed. She indicated five hours was too long.

Resident #13's record was reviewed on 7/12/11 at 11:42 a.m. Resident #13's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and debility.

A quarterly MDS (Minimum Data Set), dated 6/8/11, indicated Resident #13 was totally dependent with one person physical assist for toileting and was always incontinent.

A care plan for incontinence dated 6/4/11, indicated use briefs/pads for incontinence protection.

2. Resident #83's record was reviewed on 7/14/11 at 2 p.m. Resident #83's diagnoses included, but were not limited to, stroke and arthritis.

The resident's admission MDS (Minimum Data Set) assessment, dated 6/29/11, indicated the resident was dependent upon staff for, bed mobility, toilet use, and personal hygiene., The resident was frequently incontinent of urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A care plan, dated 6/22/11, indicated "Urinary incontinence...check and change q (every) 2 o (hours)...keep resident clean and dry..." Resident #83 was observed on 7/14/11 at 11:05, 11:55 a.m., and 1:40 p.m., lying in bed on her back. Resident #83 was observed on 7/14/11 at 1:50 p.m., during a skin check with CNA #9, CNA #10, and LPN #11 present. The resident's incontinence brief was saturated with urine. The resident had been incontinent of bowel also. The resident's draw sheet and fitted sheet under the brief were both wet with urine. During an interview on 7/14/11 at 1:50 a.m., CNA #9 indicated she had last changed the resident that morning. She indicated the last time she had checked the resident she had not been wet. 3.1-38(a)(3)(A)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314 SS=E	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure residents received treatment to prevent pressure ulcers, and provide treatment to promote healing of pressure ulcers for 5 of 9 residents with pressure ulcers and 1 of 24 residents reviewed for weekly skin assessments in a total sample of 24 residents. (Residents #7, #13, #45, #48, #83, and #140) Findings include: 1. Resident #48's record was reviewed on 7/11/11 at 12:40 p.m. Resident #48's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, and stroke. Resident #48 was observed on 7/11/11 at 12:45 p.m., sitting in his wheelchair. The resident had boots on both lower extremities. A clinical health status assessment, dated	F0314	F314 Resident #48 care plan was updated and weekly measurement shows improvement. Resident #140 orders were clarified on the multipodus boots. Prealbumin level was drawn and area continues to show improvement. MD was notified of Treatment not done. Communication btwn nursing staff will continue through medicare meeting and has been enhanced to include Huddles between shifts. Resident #83 was provided care. CAN #9 was given 1:1 re-education on wound prevention. Nursing staff also re-educated on pressure ulcer prevention. Resident #45 area has since healed. Shower sheets were completed on 6/22 aand 6/29 which showed that skin assessment had been completed. Wound eval flow sheet was completed durving survey. The sock issue was addressed right away. Resident #13 area has healed. Care plan was updated. She presents as a challenge with off loading of heels and facility is trialing new devices for most	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4/4/11, indicated the resident had no pressure ulcers. The resident's Braden scale assessment indicated the resident had total score of 10, which the form indicated was high risk for developing pressure ulcers. The resident's physician's order recapitulation, dated 7/11, indicated the following: 3/24/11 Aquaphor ointment apply topically to bilateral feet daily, 6/21/11 Santyl (a debriding ointment) apply every day to right heel. 6/21/11 Uro-prep protective skin wipes apply skin prep to blister on left heel daily. 6/21/11 Resident to be evaluated for bilateral multipodus boots A care plan, dated 1/19/11 and updated 6/28/11, indicated "Pressure ulcer at risk due to diagnosis of diabetes...decreased mobility...Conduct weekly skin assessments..." A nurses' note, dated 6/22/11 at 8:22 a.m., indicated "...Assessment: Resident has dark red purple area 2.5 cm (centimeters) x 3 cm to right heel, 2 x 1.4 cm open area in center. Wound base 100% dark/black. 5 x 6 cm intact blister noted to left heel. Resident c/o (complained of) pain to bilateral heels upon assessment and stated		effective product to reduce concern. Resident #7 had shower sheets that confirmed resident had skin assessment completed. All residents with decreased mobility are at risk for this alleged deficient practice. Nursing staff were re-educated on wound prevention. Treatment nurse checked all residents with ointments to pressure ulcers to ensure they were available. Skin sweep was completed with DNS and Licensed designee to ensure residents with the potential to be affected were reviewed. Through a therapy discussion on 7/21/11, no lapse in treatment has occurred on any other resident. Residents who were on CNA #9 assignments and at risk for areas were checked and no further deficiencies found. All residents who are on lay down list are at risk, and were checked during survey with no other deficiencies found. All residents who receive showers are at risk for missing skin assessments. Skin assessments for the month of July were reviewed, any not located were immediately reassessed. DNS and/or licensed designee will review 3 high risk residents weekly for any new areas. Results of the review to be documented and trended for further education. Therapy Manager or designee will present in writing to DNS or licensed designee any changes in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that his heels had been sore for about a week." A TAR (Treatment Administration Record) dated 6/11, indicated the Aquaphor had been applied to the resident's feet on the 3-11 shift daily. The resident's pressure ulcer forms, dated 6/21/11, indicated the following: 1. Left heel pressure ulcer was 5 centimeters by 6 centimeters, was an intact blister which was dark black in color, and the stage was unable to determine on 6/21/11. The left heel was measured on 7/5/11 and was 4 centimeters by 5.2 centimeters and was an intact dark black blister. 2. Right heel pressure ulcer was 2 centimeters by 1.4 centimeters, was 100 percent necrotic and was surrounded by a 2.5 by 3 centimeter bruise dark red /purple in color. The stage was unable to be determined. The right was measured on 7/5/11 and was 1.2 centimeters by 1.8 centimeters and the stage was unable to be determined. During an interview on 7/12/11 at 10:46 a.m., LPN #7 indicated she did not know why the pressure ulcers were not found earlier if the resident had pain for a week and had received the treatment to his feet		caseload for wound care. Treatment nurse or designee to check 5 residents weekly for proper ointment in place. DNS or licensed designee to audit 5 treatments weekly for application, and will audit 10 residents daily five days a week for proper pressure ulcer prevention. DNS to audit 3 high risk resident skin assessments weekly, five days a week to ensure compliance. DNS or licensed designee to review 25 skin assessments weekly for documentation to ensure compliance. The results of the reviews will be presented monthly in QA&A until 100% compliance is achieved consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	daily. 2. Resident #140's record was reviewed on 7/13/11 at 10 a.m. Resident #140's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and anemia. A quarterly MDS assessment, dated 6/18/11, indicated the resident required extensive assistance of staff for bed mobility. The resident had an unplanned significant weight loss and had 2 unstageable pressure ulcers. A Braden scale for predicting pressure ulcer risk, dated 6/13/11, indicated the resident was at high risk. A care plan, dated 5/17/11, indicated "...pressure ulcer actual due to : Pressure ulcer present to coccyx and right heel. Assistance required in bed mobility...Nutritional and Hydration support...Treatments as ordered...Wound clinic appointments as scheduled..." A care plan, dated 7/4/11, indicated "potential for alteration in skin integrity...monitor lab results as ordered and report abnormal results to physician...provide diet as ordered and monitor nutritional status and dietary needs...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's pressure ulcer forms indicated the resident had both pressure ulcers upon admission to the facility on 3/21/11. The pressure ulcer to her coccyx was 4 by 9.1 centimeters and the stage was unable to be determined on 3/21/11. The resident's right heel pressure ulcer was 3 by 3 centimeters and the stage was unable to be determined on 3/21/11. The resident's pressure ulcer forms indicated the coccyx pressure ulcer measured 5.2 by 4.0 centimeters on 7/12/11. The resident's right heel pressure ulcer was 1.6 by 1.5 centimeters on 7/12/11. The form, dated 7/12/11, indicated physical therapy five times a week. A physician wound care order sheet from the wound clinic, dated 4/4/11 indicated "...off loading multipodus boots for heels. Air mattress and turn often to avoid pressure to sacral wound..." The resident's physician's orders lacked documentation of an order for the multipodus boots. During an interview on 7/14/11 at 11:10 a.m., LPN #7 indicated the order for the multipodus boots from the wound clinic on 4/4/11 was never followed. She indicated she was not sure how the order			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had gotten missed. A physician's order, dated 7/14/11, indicated "May use pillows to float heels instead of multipodus boot to decrease pressure to heels." A physician's order, dated 6/24/11, indicated to obtain a pre-albumin level (a test for protein levels) due to non-healing ulcer. The resident's record lacked documentation of the pre-albumin level. During an interview on 7/13/11 at 12:30 p.m., LPN #7 indicated the pre-albumin had not been done. She indicated it was being drawn now. The results of the pre-albumin level obtained on 7/13/11, indicated the level was low at 12.9, normal ranges are 17.6-36.0. During an interview on 7/13/11 at 2:45 p.m., LPN #7 indicated she had notified the physician of the pre-albumin level and he had ordered the Registered Dietician to evaluate the resident for low protein to possibly increase the protein. Resident #140's physician's order recapitulation, dated 7/11, indicated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"...6/15/11 PT (physical therapy) clarification: Resident to receive debridement...to right heel 5 X (times) week x 4 weeks...Santyl...ointment topical- day shift everyday: cleanse right heel with NS (normal saline) pat dry apply Santyl to wound with Q-tip and cover with kerlix dressing daily...Cleanse coccyx wound w/(with) NS, pat dry, pack w/ white form, apply black foam over white foam. Apply wound vac...day shift Mon (Monday) Wed (Wednesday)- Fri (Friday)...Diet...Regular...fortified foods with all meals..." Resident #140 was observed during the evening meal on 7/12/11 at 5:50 p.m. The resident had received a ground hot dog, baked beans, cole slaw, cake, milk and water for the evening meal. The resident had not received any fortified soup with her meal. During an interview on 7/13/11 at 10:40 a.m., LPN #7 indicated the resident should have received fortified soup with her evening meal last night. A physician's order, dated 7/6/11, indicated "D/C (discontinue) PT after treatment on 7/6/11." Resident #140 was observed on 7/12/11 at 5:37 p.m., lying in bed. The resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	right heel was resting on the bed. During an interview on 7/12/11 at 5:54 p.m., LPN #1 indicated she did not do the treatment to the resident's right heel. She indicated the treatment was done by physical therapy. She indicated she would be doing the treatment to the resident's coccyx pressure ulcer tomorrow (Wednesday). Resident #140 was observed with her right heel resting on the bed on 7/12/11 at 5:55 p.m., with LPN #1 present. LPN #1 placed a pillow under the resident's leg to elevate the resident's right heel off the bed. During an interview on 7/13/11 at 2:03 p.m., LPN #16 indicated physical therapy was not doing the treatment to the resident's right heel anymore. She indicated she had done the treatment when she worked on Monday (7/11/11). During an interview on 7/13/11 at 2:05 p.m., LPN #1 indicated the treatment to the resident's right heel was being done by therapy. She indicated she had not done the treatment yesterday (7/12/11) because therapy does the treatment. She indicated she had not done the treatment last Friday (7/8/11) when she worked either. She indicated she had never received in report			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that therapy was no longer doing the resident's treatment. During an interview on 7/13/11 at 2:12 p.m., LPN #1 indicated she was unable to find the Santyl to do the resident's treatment to her right heel. She indicated she had checked with physical therapy and they did not have the Santyl ointment. During an interview on 7/13/11 at 2:25 p.m., LPN #1 indicated she had called the back up pharmacy and it would be from one to three hours before the Santyl ointment was received from pharmacy. Resident #140's pressure ulcer to her right heel was observed on 7/13/11 at 2:26 p.m., with LPN #1 present. The resident's right heel was measured by LPN #1. She indicated the right heel pressure ulcer was 1.6 by 1.4 centimeters with a 0.6 by 0.5 area of yellow slough in the center. The resident's coccyx pressure ulcer was measured by LPN #1 on 7/13/11 at 3 p.m., with LPN #16 present. The pressure ulcer was 6.5 by 6.5 centimeters and was 1.7 centimeters in depth. LPN #1 indicated the pressure ulcer was a stage III. Resident #140 was observed on 7/15/11 at 11:07 a.m., lying in bed on her back. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's heels were resting on the bed. Resident #140 was observed on 7/15/11 at 11:09 a.m., with LPN #18 present. LPN #18 indicated the resident's heels were on the bed and she would reposition the resident. 3. Resident #83's record was reviewed on 7/14/11 at 2:00 p.m. Resident #83's diagnoses included, but were not limited to, stroke, arthritis, and dysphagia (difficulty swallowing). The resident's admission MDS (Minimum Data Set) assessment, dated 6/29/11, indicated the resident was dependent upon staff for bed mobility, toilet use, personal hygiene and was frequently incontinent of urine. A care plan, dated 6/22/11, indicated "Urinary incontinence...check and change q (every) 2 o (hours)...keep resident clean and dry..." A care plan, dated 6/22/11, indicated Pressure ulcer...interventions...pressure relieving device on chair/bed...daily skin inspection during care/bathing...with a report to the nurse of any areas of skin breakdown or redness...ulcer care...application of dressing ..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A physician's order, dated 7/5/11, indicated "Cleanse r (right) outer ankle NS pat dry apply Santyl c (with) Q-tip to base et (and) cover c foam & secure c tape. Cleanse R buttock c NS & pat dry apply calmaseptine Q (every) shift to area. Cleanse coccyx pat dry apply dry dressing change (indicated by a triangle) QD (every day) & prn (as needed)." The physician progress notes, dated 7/12/11, written by the Nurse Practitioner, indicated "...needs total assist c care. tq2o (turn every two hours) Contractures legs...coccyx (right) .3 x .5 x. 2 (depth)... (left) .8...x .2 x .2 ...callus periwound...R lat (side) malleous (ankle) utd (unable to determine) R coccyx - stage III, R buttock -closed...." Resident #83 was observed on 7/14/11 at 11:05 a.m., 11:55 a.m., and 1:40 p.m., lying in bed on her back. There was a pillow under the resident's ankles to keep the resident's heels off of the bed. Resident #83 was observed on 7/14/11 at 1:45 p.m., with LPN #11 present. Resident #83 was lying in bed on her back. The resident's ankles were resting on a pillow. LPN #11 indicated the resident's ankle should not be resting on the pillow. She indicated physical therapy had done the treatment to the resident's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ankle today. She indicated the resident should be turned every two hours and the resident should not have been left on her back that long. She indicated she needed help to turn the resident. She indicated she had not done the residents treatment yet today. Resident #83 was observed on 7/14/11 at 1:50 p.m., during a skin check with CNA #9, CNA #10, and LPN #11 present. There was a strong urine odor. CNA #10 indicated there was a strong urine odor. The resident's incontinence brief was saturated with urine. The resident had been incontinent of bowel also. The resident's draw sheet and fitted sheet under the brief were both wet with urine. There were two pressure ulcers noted to the resident's coccyx and one to the right buttock. The pressure ulcers did not have any dressing covering them and the pressure ulcers were contaminated with urine and bowel movement. LPN # 11 indicated the pressure ulcers should have a dressing on them. CNA #9 indicated when she had repositioned the resident last the resident had not been wet. She indicated she had last changed the resident that morning. She indicated there were not any dressings on the pressure ulcers then but she had not notified the nurse. CNA #9 indicated she was not aware if any of the pressure ulcers were			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	new or not. LPN #11 measured the stage II pressure ulcer on the resident's right lower buttock which measured 2.5 centimeters by 0.4 centimeters. The resident's coccyx pressure ulcers were measured by LPN #11, the left pressure ulcer was 0.1 by 0.2 centimeters and the right pressure ulcer was 1.9 by 0.1 centimeters. LPN #11 indicated she was not sure what stage the pressure ulcers to the resident's coccyx were. During an interview on 7/15/11 at 9:40 a.m., the DoN (Director of Nurses) indicated the pressure ulcer to the resident's right buttock had healed per the Nurse Practitioner on 7/12/11. She indicated the pressure ulcer had re-opened. 4. Resident #45 was observed laying in bed on her back on 7/12/11 at 9:07 a.m. The mattress on the resident's bed was a pressure reduction mattress. Resident #45 was observed on 7/12/11 at 11:36 a.m., in bed laying on her back. Unit Manager, LPN #8 was observed in Resident #45's room on 7/12/11 at 4:20 p.m. The resident was in bed with her heels floated off the mattress. During a skin check with LPN #8 at this time, an area was found on the left heel. LPN #8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	described the area as black, dark red with blood pooling underneath the skin. LPN #8 indicated the area was a "deep tissue injury caused by pressure." LPN #8 indicated this was the first time she had seen the area and had been unaware of the area on the left heel. During an interview on 7/12/11 at 4:45 p.m., the Nurse Practitioner indicated she was unable to determine the stage of the area. The Nurse Practitioner indicated the area was "maybe a blister that had absorbed." The Nurse Practitioner indicated the area was not a deep tissue injury. During an interview on 7/12/11 at 4:46 p.m., the DoN indicated she was going to investigate why the area had not been found. During an interview on 7/12/11 at 5:40 p.m., Unit Manager, LPN #8 indicated the area to Resident #45's left heel was 2.8 centimeters by 2 centimeters. She indicated she did not know why the area had not been found. Resident #45's record was reviewed on 7/12/11 at 3:30 p.m. Resident #45's diagnoses included, but were not limited to, malignant neoplasm of the anus, hypertension, and colostomy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A skin assessment, dated 6/5/11, indicated Resident #45 was a high pressure sore risk.

A quarterly MDS assessment, dated 6/10/11, indicated Resident #45 was an extensive assist of one staff for bed mobility, was always incontinent of urine, dependent for personal hygiene, bathing and at risk for developing pressure ulcers.

A pressure ulcer risk care plan, dated 6/15/11, indicated "Conduct weekly skin inspection, Nutritional and Hydration support, Provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, Provide incontinent care ASAP (as soon as possible) after incontinent episodes and apply barrier cream, Treatments as ordered, Low air loss mattress, Padded back to wheelchair, Turn and reposition every 2 hours and as needed, Cleanse and pat dry hands during ADL (activities of daily living) care. Skin assessment of contractured (sic) hands. Any changes, document and notify MD (medical doctor)."

A physician progress note, dated 7/12/11 and written by the nurse practitioner indicated "UTD (unable to determine) intact skin no drainage (circle with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	slash), no (circle with a slash) blanche erythema or redness, superficial not (circle with slash) boggy under purple intact skin. no (circle with slash) fluid no (circle with slash) pain...." A physician's order, dated 8/20/10, indicated "weekly skin assessment." A nurses' note, dated 6/25/11 at 10:09 p.m., indicated "...skin clean, dry and intact...heels and coccyx are good...." There was a lack of documentation in the resident's record to indicate skin assessments were completed for 6/22/11 and 6/29/11. The last documented skin assessment on 7/6/11 at 10:43 p.m., in the resident's record indicated "skin assessment: skin dry and warm to touch, no edema noted. Will continue to monitor." During an interview on 7/12/11 at 4:38 p.m., Unit Manager, LPN #8 indicated she would check the nurses' notes. The Unit Manager, LPN #8, did not provide any further information concerning the resident's weekly skin assessments. During an interview on 7/13/11 at 9:44 a.m., Unit Manager, LPN #8, indicated she had not completed a wound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evaluation flow sheet for the area to the left heel found on 7/12/11. Resident #45 was observed on 7/13/11 at 9:40 a.m., in her room up in her wheelchair with tennis shoes on. The resident did not have socks on. At 12:25 p.m., the resident was up in her wheelchair and had slipper socks on. The Unit Manager, LPN #8 indicated she had the CNA remove the tennis shoes and apply the slipper socks. 5. Resident #13 was observed on 7/12/11 at 9:09 a.m., sitting up in her Broda chair (type of wheelchair) in the rehab dining room. Resident #13 was observed on 7/12/11 at 11:35 a.m., sitting up in her Broda chair in the rehab dining room. The resident had not been moved. During an interview on 7/12/11 at 12:15 p.m., Unit Manager, LPN #8 indicated the resident was supposed to be laid down after meals. Resident #13 was observed on 7/12/11 at 12:25 p.m., being taken to her room by CNA #15. CNA #15 indicated she thought the resident was only laid down after lunch. The CNA indicated she had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gotten the resident up at 7:30 a.m., and had not provided incontinence care since getting the resident up at 7:30 a.m. The resident was placed into bed at 12:37 p.m., the resident's brief was wet and the dressing to the right buttock was soaked. CNA #15 indicated the resident was wet and the resident's dressing was wet with urine. CNA #15 indicated it had been five hours since she had gotten the resident up. At 12:40 p.m., Unit Manager, LPN #8, completed a dressing change to the ischial. LPN #8 indicated the wound was healing and smaller in size. LPN #8 indicated the base of the area was "100% pink." During an interview on 7/12/11 at 1:00 p.m., Unit Manager, LPN #8, indicated the resident should have been changed. She indicated five hours was too long. Resident #13's record was reviewed on 7/12/11 at 11:42 a.m. Resident #13's diagnoses included, but were not limited to, Alzheimer's disease, hypertension, and debility. A quarterly MDS (Minimum Data Set), dated 6/8/11, indicated Resident #13 was totally dependent with one person physical assist for toileting and was always incontinent. The MDS assessment indicated the resident was extensive two			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	person assist for bed mobility and dependent with two person assist for transfers. The MDS assessment indicated the resident had one stage three pressure ulcer. A care plan for an actual pressure ulcer, dated 6/14/11, indicated "conduct weekly skin assessment, diabetic foot monitoring, do not massage over bony prominence, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, provide thorough skin care after incontinence episodes and apply barrier cream, treatments as ordered, weekly wound assessment, keep bilateral heels offloaded (sic), encourage fluids every shift, assist to turn and reposition every two hours and prn (as necessary), supplements as ordered. diet as ordered." The care plan lacked documentation of the intervention to lay the resident down after meals. A care plan for incontinence dated 6/4/11, indicated use briefs/pads for incontinence protection. A physician's order, dated 5/25/11, indicated "Keep bilateral heels off loaded." A Braden Scale for Predicting Pressure Sore Risk, dated 6/10/11, indicated the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was at a high risk for developing pressure sores. A wound evaluation flow sheet, dated 7/5/11, indicated the resident had a pressure ulcer on the right ischium. The pressure area on 7/5/11, measured 0.4 centimeters by 0.5 centimeters with 100% slough. The wound evaluation flow sheet indicated the facility was unable to determine the stage of the wound. The wound evaluation flow sheet indicated the resident was to be laid down after meals. A wound evaluation flow sheet, dated 7/5/11 indicated a purple discoloration of the right lateral ankle. The wound evaluation flow sheet indicated to float the resident's heels when in bed. A lay down after all meals list, dated 5/5/11, indicated Resident #13's name was on the list. An undated Kardex Report (used by CNA's to provide care), for the resident lacked documentation to float the resident's heels or place the resident in bed after meals. Resident #13 was observed on 7/12/11 at 3:10 p.m., laying in bed on her right side. The resident's heels were laying on the bed and not floated.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview on 7/12/11 at 3:15 p.m., Unit Manager, LPN #8, indicated the resident's heels were not floated.

Resident #13 was observed on 7/14/11 at 11:00 a.m., the resident was laying on her right side with a pillow positioned between her legs. The resident's heels were not floated off the bed.

During an interview on 7/14/11 at 11:05 a.m., CNA #17 indicated the resident's heels were not floated.

Resident #13 was observed on 7/15/11 at 10:55 a.m., laying in bed. The resident had one heel on a pillow and the other heel was on the bed. The Unit Manager, LPN #8 indicated only one of the resident's heels was floated off the bed.

6. Resident #7's record was reviewed on 7/14/11 at 11:12 a.m. Resident #7's diagnoses included, but were not limited to hypertension, diabetes mellitus, and peripheral vascular disease.

A physician's order, dated 12/14/09, indicated weekly skin assessments.

A quarterly MDS assessment, dated 5/2/11, indicated Resident #7 required extensive one person assist for bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mobility, extensive two person assist for toileting, and was frequently incontinent of bowel and bladder. The quarterly MDS assessment indicated the resident was at risk for developing pressure ulcers. A care plan, dated 5/11/11, indicated Resident #7 was at risk for pressure ulcers. The nurses' notes indicated a weekly skin assessment was completed on 7/7/11, 6/30/11, 6/24/11, and 6/17/11. There was a lack of documentation weekly skin assessments had been completed for 6/10/11 and 6/3/11. During an interview on 7/14/11 at 2:40 p.m., the Unit Manager, LPN #8, indicated she could not find the weekly skin assessments, but she was "still looking." A facility policy, titled "Skin Integrity Guideline," dated 1/11, indicated "To provide a systemic approach and monitoring process for skin. To decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions...develops a routine to review residents with wounds or at risk on a weekly basis...licensed nurse will be responsible for performing this skin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessment/observation...determine care plans consistently implemented, evaluated and revised based on the needs of the resident...." 3.1-40(a)(1) 3.1-40(a)(2)			
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the facility failed to obtain blood pressure readings prior to administration of an anti-hypertensive medication as ordered by the physician for 1 resident in a sample of 24 residents reviewed for unnecessary medications in a total sample of 24. (Resident #135) Findings include: Resident #135's record was reviewed on 7/12/11 at 4 p.m. Resident #135's diagnoses included, but were not limited to, dementia, hypertension, stroke, and failure to thrive. A physician's order, dated 5/23/11, indicated metoprolol tartrate (blood pressure medication) 25 milligrams twice a day. Hold if systolic blood pressure less than 90 or greater than 200. The resident's Medication Administration Records (MAR's) indicated there were no blood pressures documented 5/24/11 through 5/31/11, 6/1/11 through 6/30, and 71/11 through 7/12/11. During an interview on 7/12/11 at 4:37 p.m., LPN #7 indicated the nurses should have taken the resident's blood pressure prior to administering the resident's blood pressure medication.	F0329	F329 Resident #135 MAR was clarified to include area for documentation of B/P results. Any resident who receives an anti-hypertensive medication is at risk for this alleged deficient practice. Licensed nursing staff were re-educated on following physician orders. DNS or licensed designee will review 15 MARs weekly to ensure compliance of following phys orders. The results of the reviews will be presented monthly in QA&A until 100% compliance is achieved consecutively for 3 months.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(a)(3)			
F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 3 of 9 residents in a supplemental sample of 9 (Residents #65, #130, and #150) observed receiving medications. 4 errors in medication administration were observed during 41 opportunities for error in medication administration. This resulted in a medication error rate of 9.75%. (LPN #1, RN #2, and RN #3) Findings include: 1. During a morning medication administration pass observation on 07/12/11 at 8:53 a.m., LPN #1 prepared Resident #150's eye drops, which included Fluorometholone (corticosteroid eye ointment) 0.1%. The Medication Administration Record (MAR), dated 07/11, indicated an order for Fluorometholone ophthalmic 0.1%, every four hours apply a 1/2 inch strip to both eyes when the resident was awake.	F0332	F332 Resident #150 medication was ordered with the correct label. LPN was re-educated 1:1 concerning proper med pass. Resident #130 meds were clarified same day to be given as available. RN #2 received 1:1 re-education on med pass and re ordering of medications. RN#3 also received 1:1 re-education on following phys orders and proper med pass. Resident #65 medications were clarified and nurse went back and gave medication as ordered. Residents with orders for eye drops are at risk for this alleged deficient practice. All other orders for eye drops in month of July were reviewed and were with correct labeling. All residents receiving medication are at risk, a 100% audit was completed for all meds and reordered as needed. DNS or licensed designee will observe 3 nurses weekly administer eye drops and medication to ensure MAR and phys orders are followed. DNS or licensed designee will review 5 residents medications for	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	LPN #1 applied a 1/2 inch strip to Resident #150's left eye at 9:05 a.m., and then LPN #1 removed her gloves and washed her hands and left the resident's room. LPN #1 indicated she was finished with the resident's eye medications at 9:10 a.m. on 07/12/11. LPN #1 indicated the label for the Fluorometholone indicated the resident was to receive the ointment only in the left eye. LPN #1 then reviewed the resident's MAR and then indicated she should have given the Fluorometholone in both eyes. A physician's order, dated 07/09/11, reviewed on 07/12/11 at 9:15 a.m., indicated an order for Fluorometholone ointment, apply 1/2 inch strip to both eyes every four hours when awake. 2. During a morning medication administration pass observation on 07/12/11 at 9:45 a.m., RN #2 prepared Resident #130's medication, which included a Lidoderm (anesthetic) patch 5% to the lower back, two Lidoderm patches for the resident's bilateral knees, and should have included Baclofen (skeletal muscle relaxant) 10 mg (milligrams).		availability weekly for compliance. Results of the observations and review will be brought to QA&A monthly for compliance and quality review until 100% compliance is met consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's MAR, dated 07/11, indicated the following orders: Lidoderm 5% patch daily to the lower back, on at 8 a.m. and off at 8 p.m. Lidoderm 5% patch daily to the bilateral knees, on at 8 a.m. and off at 8 p.m. Baclofen 10 mg, two times daily at 9 a.m. and 5 p.m. RN #2 indicated on 07/12/11 at 9:45 a.m., the resident did not have the Baclofen medication in the medication cart and she would have to look in the Emergency Drug Kit for the medication. RN #2 then applied the Lidoderm patches as ordered at 10 a.m. During an interview on 07/12/11 at 10 a.m., RN #2 indicated the patches were applied late. She indicated the patches were supposed to be applied at 8 a.m. At 10:30 a.m. RN #2 then went to the Emergency Drug Kit (EDK), which was stored in the Medication Room. RN #2 then indicated the EDK did not contain Baclofen 10 mg. She indicated she would need to call the pharmacy. She indicated she could not give the morning dose of Baclofen.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The resident's Physician's Recapitulation orders, dated 06/11, reviewed on 07/12/11 at 10:45 a.m., indicated orders originally dated 05/27/10 for Lidoderm patches 5% apply to the lower back and bilateral knees daily, on at 8 a.m. and take off at 8 p.m. The resident's Physician's Recapitulation orders, dated 06/11, reviewed on 07/12/11 at 10:45 a.m., indicated an order originally dated 08/27/10 for Baclofen 10 mg, two times a day. 3. During an evening medication administration pass observation on 07/12/11 at 4:26 p.m., RN #3 prepared Resident #65's medication, which should have included Depakote Sprinkles (anti-seizure medication) 250 mg, give two capsules (500 mg) twice a day. RN #3 indicated the resident did not have the Depakote medication in the medication cart. She indicated she would check to see if there was Depakote in the EDK. RN #3 then went to the Medication Room and indicated the EDK contained Depakote 125 mg. RN #3 indicated the resident would need two capsules of the Depakote 125 mg. RN #3 then removed two capsules of Depakote 125 mg from the EDK at 4:42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m. and placed the two capsules in a plastic medication cup. At 4:50 p.m., RN #3 then administered the two Depakote 125 mg capsules to the resident. RN #3 then washed her hands and exited the resident's room, initialed the MAR and then started to move the medication cart down the hallway. During an interview on 07/12/11 at 4:50 p.m., RN #3 indicated she did not give the correct amount of Depakote. She indicated she should have given four of the 125 mg capsules. The resident's Physician's Recapitulation Orders, dated 06/28/11, were reviewed on 07/12/11 at 5 p.m. The orders indicated an order originally dated 10/08/10 for Depakote Sprinkles, 250 mg, two capsules twice a day. A facility policy, dated 09/10, titled, "Medication Administration General Guidelines", received as current from the Director of Nursing, indicated, "...Medications are administered in accordance with written orders of the prescriber...Verify medication is correct three (3) times before administering the medication...Medications are administered within 60 minutes of scheduled time..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-48(c)(1)			
F0360 SS=E	The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Based on observation, record review, and interview the facility failed to provide residents' supplements to meet the special dietary needs of each resident for 4 of 10 residents reviewed with supplements in a total sample of 24 (Residents #59, #97, #129, #140) and 1 of 9 residents in a supplemental sample of 9 (Resident #65). Findings include: 1. Resident #59's record was reviewed on 7/12/11 at 9:30 a.m. Resident #59's diagnoses included, but were not limited to, diabetes, hypertension, and dementia.	F0360	F360 Resident #59 received sandwich after meal pass but before dinner service was completed. Resident #97 and #140 received her fortified soup before dinner service was completed as well. Resident #129 did not get her ice cream, dietary staff was given 1:1 on the importance of ensuring all supplements are on trays prior to delivery of the meal. Any resident with orders for supplemental items with all meals are at risk for this alleged deficient practice. Dietary Manager inserviced his staff regarding meal tickets and following supplement orders on tickets. Dietary Manager also	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation of the evening meal, on 7/12/11 at 5:57 p.m., Resident #59 received a ground hot dog on a bun, baked beans, cole slaw, and Boston creme pie. The resident did not receive an extra sandwich. A physician order, dated 6/28/11, indicated the resident was supposed to get a sandwich with all meals. During an interview with the Registered Dietician, on 7/12/11 at 10:25 a.m., she indicated the resident was supposed to get a sandwich with all meals. 2. Resident #97's record was reviewed on 7/13/11 at 12:05 p.m. Resident #97's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, and hypertension. During an observation of lunch, on 7/11/11 at 12:40 p.m., Resident #97 received lasagna, bean medley, garlic bread, ice cream and 2 slices of bread. A physician order, dated 8/24/10, indicated fortified foods with lunch and supper. During an interview with Dietary Supervisor #5, on 7/11/11 at 12:55 p.m., he indicated residents on fortified foods		reviewed all current supplement orders and verified that all tickets match current orders. Exec Director or designee will audit 10 trays of residents with special dietary needs weekly to ensure that all foods ordered are delivered at time of meal pass. Dietary manager to also audit the tray line 2 times a week to ensure that all procedures are followed for completing meal pass preparedness. Results of these audits will be brought to QA&A monthly for compliance and quality review until 100% compliance is met consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	are supposed to get fortified soup at lunch and dinner. 3. Resident #140's record was reviewed on 7/13/11 at 10 a.m. Resident #140's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and congestive heart failure. The resident's physician's orders recapitulation, dated 7/11, indicated the resident was to receive fortified foods with all meals. Resident #140 was observed during the evening meal on 7/12/11 at 5:50 p.m. The resident had received a ground hot dog, baked beans, coleslaw, cake, milk and water for the evening meal. The resident had not received any fortified soup with her meal. During an interview on 7/13/11 at 10:40 a.m., LPN #7 indicated the resident should have received fortified soup with her evening meal last night. 4. Resident #129 food tray was observed during the evening meal on 7/12/11 at 5:48 p.m. Resident #129 was observed not to receive ice cream on her tray. Resident #129's undated menu card indicated "ice cream 4 oz (ounces)."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview on 7/12/11 at 5:50 p.m., LPN #14 indicated Resident #129 was supposed to receive a container of ice cream.

Resident #129's record was reviewed on 7/13/11 at 9:50 a.m. Resident #129's diagnoses included, but were not limited to, dementia, depression, and anxiety.

A physician's order, dated 5/11/10, indicated "Supplement:..Special Instructions: Add ice cream oral two times per day."

During an interview on 7/13/11 at 10:20 a.m., the RD indicated she had talked to the kitchen staff concerning the ice cream.

5. During an evening medication administration pass observation on 07/12/11 at 4:26 p.m., RN #3 prepared Resident #65's medication and 2-Cal nutritional supplement. RN #3 poured the 2-Cal into a plastic glass without measuring the supplement. RN #3 indicated she thought the glass held 125 cc's (cubic centimeters) of liquid. RN #3 then stated, "they always say to give her a cup full." RN #3 then measured the 2-cal from the plastic cup and indicated there were 105 cc's of 2-cal in the glass. She then indicated she needed to add another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	15 cc's to make 120 cc's of 2-cal as ordered. The resident's Medication Administration Record (MAR), dated 07/11, indicated to give 2-Cal supplement 120 cc's, twice a day. The resident's Physician's Recapitulation Orders, dated 06/28/11, indicated an order for 2-Cal supplement, 120 cc's, twice a day. 3.1-20(a)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the	F0371	F371 Cook #4 was given 1:1 education on requirement for wearing	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to distribute and serve food under sanitary conditions related to: Gloves not worn while peeling and slicing bananas, which had the potential to affect 144 residents who consume food prepared in the kitchen. (Cook #4) Dirty cabinets, toaster oven, and bread maker in the Cottage Unit, which had the potential to affect 15 residents who live on the Cottage Unit. Findings include: 1. During an observation of the kitchen on 07/11/11 at 11:55 a.m., Cook #4 was standing at the counter peeling bananas and then slicing the bananas and placing the slices in a bowl on the counter. Cook #4 handled the bananas during the slicing and placing the slices into the bowl. Cook #4 did not have gloves on. During an interview at the time of the observation, Cook #4 indicated the bananas were being sliced for the noon meal on 07/14/11. During an interview on 07/11/11 at 12 p.m., Dietary Supervisor #5 indicated the cook was supposed to have gloves on. He indicated they would need to cut up all new bananas.		gloves while preparing fruit. Fruit was discarded and all new bananas were sliced. The dirty cabinets on the AACU were cleaned and bottom cabinets screwed shut to eliminate future use of area. Toaster oven and Bread maker were cleaned and stored with AC Director so that they are kept in office until future use for supervised resident activity. Residents who consume foods from the kitchen are at risk for this alleged deficient practice. Kitchen staff have been educated and monitored to ensure that all sanitary requirements are maintained for food preparation. Exec Director or designee will monitor the kitchen 3 times weekly for food prep to ensure gloves are being worn as per policy. 4. Results of this review will be brought to QA&A monthly for quality review until 100% compliance is met consecutively for 3 months	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The menu for 7/12/11 for the noon meal indicated "open faced turkey and (sandwich)...banana slices..." 2. During the environmental tour on 07/14/11 at 10:25 a.m. through 11:55 a.m., with the Administrator, Housekeeping Supervisor, and Maintenance Director, the following was observed: A) There were two dirty bottom cabinets in the Cottage Unit Dining Room. There was a toaster oven stored in one of the cabinets. The toaster oven had pieces of dried food on the inside. The other cabinet had a bread maker with an accumulation of dried bread crumbs in the bottom of the bread maker. During an interview at the time of the observation, the Alzheimer's Care Unit Director (ACU Director) indicated the toaster oven had been used 07/13/11. 3.1-21(i)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0385 SS=D	A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on record review and interview, the facility failed to ensure a physician provided medical care to a resident when the resident's physician had not responded to the facility staff to treat a skin issue, for 1 of 24 resident's reviewed for physician response for medical care in a total sample of 24. (Resident #48) Findings include: Resident #48's record was reviewed on 7/11/11 at 12:40 p.m. Resident #48's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's disease, and stoke. Resident #48's nurses' note indicated: 5/12/11 at 9:49 p.m. "(Physician name) paged per beeper no answer, also page through answering service about resident small excoriation noted to scrotum..."	F0385	F385 MD has since been notified. Exec Director also addressed concern with the MD timeliness of response. Residents who are under the care of a physician are at risk for this alleged practice. Nursing staff were re-educated to notify the DNS when MD does not return call so that Medical Director can be notified and documentation can take place showing the attempts to contact. DNS or licensed designee will review nursing notes for concerns of physician not responding to facility daily and follow up with Medical Director with any trends identified during review. Letters will be sent to physicians who are repeat offenders to make sure they understand the severity of their inaction. Progress and review of the trends will be reviewed in QA&A monthly to ensure that the Medical	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5/12/11 at 10:51 p.m., "(physician name) answering service called and his cell phone also message left to have MD call..." 5/12/11 at 10:55 p.m., "...will continue to call (physician name) for further orders..." 5/13/11 at 11:00 p.m., "...5 X (by) 13 cm (centimeter) noted to scrotum area. (physician name) paged several time (sic) still no return call..." 5/16/11 at 8:16 p.m., "(Physician name) notified of resident excoriation on the scrotum...." This was 4 days after the excoriation was first found and attempts made to inform the physician. During an interview on 7/12/11 at 9:55 a.m., LPN #7 indicated the nurses were supposed to call the medical director if they could not reach the resident's physician. 3.1-22(b)(1) 3.1-22(b)(2)		Director and quality committee is ware of the Physicians that make compliance more difficult.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on record review and interview, the facility failed to ensure residents received Mantoux (tuberculin) tests for 5 of 24 residents reviewed for Mantoux tests in a total sample of 24. (Resident's #39, #68,	F0441	F441 Resident #39, 68, 135, 140, 152 all received their first and second step mantoux by date certain. A new director of clinical education has control of this process and was	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#135, #140 and #152) Finding include: 1. Resident #140's record was reviewed on 7/13/11 at 10 a.m. Resident #140's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and congestive heart failure. The resident's admission date to the facility was 3/21/11. The resident's TB (tuberculosis) Screening form, indicated the resident had received a Mantoux test on 3/4/11 at the hospital, which had been read on 3/7/11. There was a lack of documentation of a second step Mantoux test for the resident. During an interview on 7/13/11 at 10:45 a.m., LPN#7 indicated she was unable to find where a second step Mantoux had been done for the resident. 2. Resident #152's closed record was reviewed on 7/14/11 at 8:30 a.m. Resident #152's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and Alzheimer's disease. Resident #152 had been admitted to the facility on 5/6/11. The resident's TB (tuberculosis) Screening form, indicated a lack of documentation of any Mantoux tests being done.		already auditing and completing the in house review as scheduled. Any resident who is ordered to receive the Mantoux test is at risk for this alleged deficient practice. An audit has been compiled and completed by date certain to ensure that all residents in house have received their appropriate steps. A new communication form is being used upon admission to ensure that the infection control nurse is aware at time of admit what step to perform and will maintain a file organized to ensure all steps are done per policy guidelines. Monthly admissions will be reviewed in QA&A to ensure that all admissions received their steps timely. 100% compliance must be met for 3 months thru committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

During an interview on 7/14/11 at 11:10 a.m., LPN #7 indicated the resident had not had any Mantoux testing done.

3. Resident #135's record was reviewed on 7/12/11 at 4 p.m. Resident #135's diagnoses included, but were not limited to, dementia, hypertension, stroke, and failure to thrive. Resident #135 had been admitted to the facility on 5/23/11.

The resident's TB (tuberculosis) Screening form, indicated the resident had a Mantoux test on 6/28/11. This was over one month after the resident had been admitted to the facility. There was a lack of documentation of a second step Mantoux test being completed.

During an interview on 7/13/11 at 10:30 a.m., LPN#7 indicated Resident #135 had not received the first step Mantoux test until June 2011 and no second step had been done.

4. Resident #68's record was reviewed on 7/15/11 at 9:45 a.m. Resident #68's diagnoses included, but were not limited to, dementia, congestive heart failure, and chronic kidney disease. Resident #68 was admitted to the facility on 5/11/11.

An immunization record indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	tuberculosis testing was done on 4/19/11 at the hospital and the result of 0 mm (zero millimeters of induration, negative result) was read on 4/22/11. There was lack of documentation of a second step being done. There was lack of documentation on the MAR (Medication Administration Record) or the TAR (Treatment Administration Record) of a second step. A TB (Tuberculosis) Screening/Risk Assessment Form indicated on 6/28/11 a Mantoux (TB skin test) was given. During an interview with the DoN (Director of Nursing), on 7/15/11 at 9:55 a.m., she indicated it wasn't documented that a second step was given. She indicated the whole program has been "revamped" and that was why the Mantoux was given on 6/28/11. A facility policy titled "Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests," dated December 2006 and received as current from the Administrator, on 7/14/11 at 2:45 p.m., indicated ...Individuals with <10 mm of induration...will receive a booster (second step) of 0.1 ml (milliliters) (5 tuberculin units) of PPD (purified protein derivative,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Mantoux) one to two weeks after the initial TST (tuberculin skin test)..." 5. Resident #39's record was reviewed on 07/15/11 at 8:40 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension. A TB (Tuberculosis) Screening/Risk Assessment form, indicated an annual Mantoux test had been given on 12/09/10. The form lacked documentation the Mantoux test had been read three days after the test had been given on 12/09/10. During an interview on 07/15/11 at 9:15 a.m., the Staff Educational Coordinator indicated the nurse who gave the Mantoux was no longer employed by the facility. She indicated a Mantoux test had just been given to the resident once the missing Mantoux tests had been brought to the facility's attention. 3.1-18(e) 3.1-18(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0465 SS=E	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the outsides of ice machines were kept clean related to dust accumulation on the vents of the ice machines on the C and D Units, which had the potential to affect 98 residents who received ice on the C and D Units and the accumulation of cobwebs and dirt behind the ice machine in the Nutritional Pantry for the Alzheimer's Care Unit and the Cottage Unit, which had the potential to affect 46 residents who received ice on the units. Findings include: 1. During the environmental tour on 07/14/11 at 10:25 a.m. through 11:55 a.m., with the Administrator, Housekeeping Supervisor, and Maintenance Director, the following was observed: A) There was an accumulation of dirt and cobwebs behind the ice machine in the Nutritional Pantry for the Alzheimer's and Cottage Care Units. During an interview at the time of the observation, the Maintenance Director indicated the ice machine is pulled out	F0465	F465 Ice machine vents were cleaned, cobwebs and dirt behind ice machines swept, same day as tour. Cleaning schedule was revised to include the detail of vents on the ice machines as well as moving the machines to clean behind on floors. Education was provided to housekeeping staff on this process. Executive Director or designee and Housekeeping supervisor or designee to make rounds 5 times a week jointly to ensure that areas are kept clean and sanitary. Results of rounds to be reviewed in QA&A for 3 months to ensure compliance.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and cleaned behind semi-annually. He indicated he would change the cleaning to quarterly. B) There was an accumulation of dust on the vents of the ice machines in the C and D Wing Nutritional Pantries. At the time of the observations, the Administrator acknowledged the dust on the vents. 3.1-19(f)			
F0507 SS=D	The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Based on record review and interview, the facility failed to ensure resident's laboratory reports were in the residents' records for 2 of 24 residents reviewed for labs in a sample of 24. (Residents #68 and #152) Findings include:	F0507	F507 Resident #68 and #152 lab faxed results and were put in residents charts. Residents that received orders for lab are at risk for this alleged deficient practice. Residents in the month of July with lab orders were reviewed to ensure all lab results were back and in chart as noted. DNS or licensed designee will audit	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Resident #68's record was reviewed on 7/15/11 at 9:45 a.m. Resident #68's diagnoses included, but were not limited to, dementia, congestive heart failure, and chronic kidney disease. A. A nurse's note, dated 6/15/11 at 8:35 a.m., indicated "(physician's name) office called into facility new order noted and received for lab TSH (thyroid stimulating hormone) on Thursday. Fax results to M.D. @ (fax number)..." The record lacked results of the TSH. B. Nurses' notes indicated the following: 5/25/11 at 11 :46 p.m., indicated "...MD ordered for wound re-culture..." 5/26/11 at 2:45 p.m., indicated "...Wound culture obtained and spoke with (name of lab) for specimen pick up..." 5/27/11 at 6:40 a.m., indicated "...wound culture pending..." 5/27/11 at 9:19 p.m., indicated "...Awaiting results from wound culture..." 5/27/11 at 11:29 p.m., indicated "Awaiting results from wound culture..." 5/28/11 at 3:06 a.m., indicated "...wound		the lab book five times a week to ensure that all orders are being followed up on and received timely per policy. Results of this audit will be brought to QA&A monthly for quality review until 100% compliance is met consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	culture pending at this time..." 5/28/11 at 12:10 p.m., indicated "...Wound culture pending..." 5/29/11 at 1:51 p.m., indicated "...Wound culture pending..." There was lack of documentation after 5/29/11 of wound culture results being received. The record lacked results of the wound culture. During an interview with LPN #7, on 7/15/11 at 11:35 a.m., she indicated the TSH was done and so was the wound culture, but the results were not in the chart. The lab was going to fax over the results. 2. Resident #152's closed record was reviewed on 7/14/11 at 8:30 a.m. Resident #152's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and Alzheimer's disease. A physician's order, dated 5/14/11, indicated HgbAIC (test for control of blood sugars) every 3 months. The resident's record lacked documentation of the results of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	HgbAIC. During an 7/14/11 at 11:10 a.m., LPN #7 indicated the results of the HbgAIC were not in the resident's record. 3.1-49(f)(4)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure medical records were complete and accurate for 1 resident in a sample of 24 residents whose records were reviewed for accuracy related to documentation of a port-a-cath (access site under the skin to deliver medication) for resident #69. (Resident #69)	F0514	F514 Port a cath was flushed for resident #69. Nurse received 1:1 re-education concerning documentation of flush. Any resident with a order for a port a cath flush are at risk for this deficient practice. All resident with an order in July were reviewed with no other deficiencies' noted. RN staff were re-educated on port a cath flushes and documentation.	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Resident #69's record was reviewed on 7/13/11 at 11:20 a.m. Resident #69's diagnoses included, but were not limited to, heart failure, cerebrovascular disease, and hypertension. A physician's order, dated 5/9/11, indicated "Access pac (port-a-cath) and flush per protocol for maintenance monthly..." Resident #69's MAR (Medication Administration Records) for June 2011, indicated the port-a-cath should have been flushed 6/18/11. There was no documentation to indicate the port-a-cath was flushed. The resident's MAR for July 2011, indicated the port-a-cath should have been flushed on 7/8/11. There was no documentation to indicate the port-a-cath was flushed. During an interview on 7/13/11 at 3:15 p.m., the ADoN (Assistant Director of Nursing) indicated she had talked with the RN and the port-a-cath had been flushed in June. The ADoN indicated the RN had forgotten to initial the June 2011, MAR. 3.1-50(a)(1)		DNS or designee will audit all Port a cath residents for proper documentation. Results of this audit will be brought to QA&A monthly for quality review until 100% compliance is met consecutively for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-50(a)(2)			
F0516 SS=B	A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. Based on observation and interview, the facility failed to safeguard closed clinical records and resident records against loss and destruction for 1 of 1 Medical Records office, related to 5 resident files and thinned out forms not protected from the sprinkler system. Findings include: During an observation of the Medical Records office on 07/14/11 at 11:40 a.m., with the Administrator and Medical Records Clerk present there were five resident medical records and numerous resident forms sitting on top of the filing	F0516	F516 Rubber containers were purchased for medical records to store un-filed work at the end of each working day. Education was provided to medical records regarding the importance of safeguarding all records from hazardous situations with water and fire. Exec Dir or designee will audit medical records office 2 times weekly to ensure that containers are being used for paperwork not filed at the end of each working day. Results of this audit will be brought to QA&A monthly for quality review until 100% compliance is met consecutively for 3 months	08/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155362	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MERRILLVILLE	8800 VIRGINIA PLACE MERRILLVILLE, IN46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cabinets. At the time of the observation, the Medical Records Clerk indicated the five medical records were records of residents who had been discharged. She indicated the numerous forms were thinned out papers from the residents' medical records, which needed filed. She indicated she leaves them on the file cabinets until they are filed. She indicated they were not protected from the sprinkler system. 3.1-50(d)			